Sonia Juneja, MD
Patient Registration and Acknowledgement of Forms

Demographic Information

Today's date: ______/_____/_____

Full legal name: ______________________________ Preferred name:_______________________________

Marital status: ____ Married ______Single ________Divorced ______separated ______widowed _____Other
Gender: _____ Male ______ Female
Date of Birth: ____/____/____ Age: __________
Social Security no:_____________________ Driver's License number: ___________________
Address: ____
City, State, Zip:____
Cell phone:____ Ok to leave message?_______ Yes ______No
Home phone:_____________________________________ Ok to leave message?_______ Yes ______No
Work Phone:____________________________________ Ok to leave message?______ Yes ______No
Email:____ Ok to send message?______ Yes ______ No

Guarantor/Financially Responsible party
Name:___________________________ Relationship to the patient:____________________________________
Address:____
Tel:____

Spouse/Partner's full name:____

Occupation:____
Employer/Address:____

Referring/Primary care physician:____
Address/Phone:____

How did you hear about my practice?____
What was the main reason why you chose my practice?____

In Case of Emergency
name of local friend or relative (not living at the same address):____
Relationship:________________________________ Home phone: ____
Cell:______________________________________ Work Phone:____

The above information is true to the best of my knowledge. I certify that this office has provided me a copy of its ***Policies and Procedures for patients and Consent for treatment***, and I agree to its terms, including the payment policy, email policy and no show policy. I certify that the office has given me an opportunity to review its ***Notices of Privacy Policies***, and I agree to its terms. I understand that I am responsible for payment in full at the time services are rendered. I understand that Dr. Juneja does not participate with Insurance plans and she has opted out of participation with Medicare, and the Medicare beneficiaries cannot submit claims for payment to Medicare for services rendered by Dr. Juneja. I authorize Dr. Juneja to release medical Information to my referring or primary care physician to assist with continuity of care. This release will expire one year from the date of my signature below, unless I cancel this release in writing prior to that date.

Signature:____ Date:_______________________

Sonia Juneja, M.D.
Washington Family Psychiatry LLC
5225 Pooks Hill Rd Bethesda, MD 20814.
Tel: (240) 428-4792

NOTICE OF PRIVACY PRACTICES

Welcome to my practice!! Please take a few minutes to read through these guidelines.

Each time you visit the office, a record or your visit is made. This record contains your symptoms, diagnosis, treatment and plan for future care and treatment. It serves as the basis for planning your care and treatment. However, it can also act as a legal document describing the care you received and as a means by which you or a third party payer can verify that the services billed were actually provided. It may also be a means of communicating with other health professionals who contribute to your care. Understanding what is in your records and how your health information is used helps you to ensure its accuracy, better understand, who, what, when, where and why others may access your health information, and make more informed decisions when authorizing release to others.

Your Health Information Rights

Although your record is the physical property of Sonia Juneja, M.D., the information belongs to you. You have the right to:
- Request restriction on certain uses of your information
- Obtain a paper copy of the Notice of Privacy Practices
- Request communications of your health information by alternative means
- Revoke your authorization to use your health information except to the extent that action has already been taken or is required by law

My Responsibility

I, Sonia Juneja, am required to:
- Maintain the privacy of your health information
- Provide you with the notice of my legal duties and privacy practices with respect to the information I collect about you
- Abide by the terms of this notice
- Accommodate reasonable requests you may have to communicate health information by alternative means
- I will not use or disclose your health information without your authorization, except as described in this notice.

Communication, Scheduling and Appointment Policy

I do not have an office assistant. When you call the office, you will have to leave a message through an answering service. For non urgent calls, I will return the call no later than the next business day. Should you need to talk with me urgently, please call my office and leave a message with my answering service. I will make every effort to return your call within 4 hours.

However, I will not conduct a therapy session over the phone. If you feel you or your child is in danger in any way, please call 911 or go to the nearest emergency room. If you have an emergency such as a serious side effect to a medication or concerning symptoms, please call my office number and my answering service will contact me. Appointment requests may be made by calling my office phone. When you schedule an appointment, that time is reserved for you alone. I never double book as some practices do. Because of this, I require 48 hours notice to change or cancel an appointment or I must charge the full fee for the time (Monday appointments would need to be called about on the time preceding Friday). Any exceptions to this will be at my discretion.

Confidentiality

All communication between physician and patient is held in the strictest confidence unless:
- the patient authorizes release of information with a signature.
- the physician is ordered by a court to release information.
- child or elder abuse/neglect is suspected.
- I become concerned for the patient's safety or the safety of others.

In the case of safety concerns, I am required by law to inform authorities and/or potential victims.

Payment

My practice is a private pay outpatient practice. I do not participate with any insurance plans or managed care companies and a considered "out-of-network" or "non-participating." This allows me to practice psychiatry without any outside interference or administrative burdens.

Payment is due in full at each session. My practice accepts cash (correct change), checks and credit cards. I do not accept check’s for the initial visits, please bring correct change and/or your credit card for the first initial appointment.

Patients may elect to seek reimbursement from their insurance company as most health insurance plans provide some outpatient mental health benefits. It is your responsibility to contact your insurance plan to establish if you have out-of-network benefits, what you will be reimbursed if you do, and how to submit your claim(s) directly to your insurance plan. I will provide you with a statement (receipt) reflecting all the relevant codes and information, including charges, payments, diagnostic codes, procedure codes and my Federal ID number.

Generally, you should be able to collect directly from your health insurer if you do the following;

- Keep your receipts - A receipt will be provided to you at the end of each session.
- File for reimbursement - Complete the insurance form provided by your insurance company, attach the receipt provided by me to this form, and send these documents to your insurance company, requesting that you be paid rather than the physician. If there is no pace to specify paying you rather than the physician, write the following in red in on your insurance form: "Pay subscriber, not provider."
- Always retain a copy of the form and receipt that you send to the insurance company.

Prescriptions
It is my policy to provide prescriptions only during an office visit. I write prescriptions with sufficient refills to last until we are due for a routine scheduled follow up. It is in everyone's best interests for me to make a periodic reassessment in person before renewing a prescription. Usually, I am booked up to one month in advance, so schedule your follow up appointment as you leave or call for an appointment before you are down to a 30 day supply to avoid running out of the medication. I WILL NOT call or fax in any prescription for this reason, except for a small amount to avoid an interruption in medication. I make exceptions at my discretion in case of true emergency, prescription changes or other rare circumstances.

Other Providers
Since many psychiatric symptoms can be caused or exacerbated by medical illness, I strongly suggest that you have a primary care physician to consult so that medical causes of symptoms can be ruled out. If applicable, I will be happy to send a letter to your primary physician describing the evaluation, diagnosis, and treatment recommendations at your request and with your authorization.

Psychotherapy
I usually recommend psychotherapy as either a primary treatment or as a additional treatment along with medications. With your authorization, I will be happy to consult with your therapist if you already have one.

Hospitalization
I have an outpatient only practice and do not see patients in the hospital. Should you have a psychiatric illness that may require hospitalization. I will make every effort to help you coordinate your care with the hospital of your choosing. If an emergency arises, you should call 911 or go to the nearest hospital emergency room to ensure safety.

Problems & Communication
If you are experiencing any problems, either as a result of a treatment side effect or due to an issue in our therapeutic relationship, please do not hesitate to discuss it with me. You're well being is my highest priority.

Consent for Treatment
By your signature on the Patient Registration Form, you acknowledge that you are presenting yourself or your child to Sonia Juneja, M.D., for evaluation, diagnosis, and/or treatment of a medical or psychiatric condition. You give consent and authorize Dr. Sonia Juneja to order and/or perform all exams, tests, procedures, and any other care deemed necessary or advisable for the evaluation, diagnosis, and treatment of this medical condition. This consent is valid for each visit made to the office, unless and until revoked in writing.

By your signature, you acknowledge that you have read and understand the information obtained in this consent and the policies and procedures. You accept the terms of this consent and the policies and procedures of this practice.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.
Patient Name ____
Address ____
____
Date of Birth ______________________

For this authorization, "My Health Information" means (check all that apply) and may include information regarding substance abuse treatment:

Hospital Records
____Emergency Room Record ____Psychiatric Admission Note
____Admission Physical ____Psychiatric Evaluation/Diagnosis
____ Psychosocial Assessment ____Progress Notes
____Drug & Alcohol Treatment Record ____Discharge summary
____Diagnostic Tests/Results (Lab, X-rays, and other Test Results)
____All of the above ____ Other ________________________

Outpatient Records
____ Initial Diagnostic Evaluation ____ Progress notes
____Medication Records ____Treatment Plans
____Psychological Testing ____Summary of Treatment
____ Medical Records ____ All of the above

For the date(s) of service starting/ending____
I authorize Sonia Juneja, M.D. to ________Release My Health Information
________Receive My Health Information
From/To Name ____
Address ____
____

For the following purpose:
_____Coordination of medical care
_____ Providing information to workplace or insurance for disability, leave of absence, or to assist in payment
_____ Obtaining or providing collateral information to facilitate care
_____ Providing clinical information to state or regulatory agencies
_____ Other____

I understand that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Sonia Juneja, M.D.. I understand that a revocation is not effective to the extent that the Practice has relied on this authorization in its actions. I certify that I have read, signed and received a copy of this authorization upon my request. I understand I may be billed for copies of my medical record according to HIPAA State of Maryland and Federal Law.

Patient's Signature__________________________________ Date________________

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CREDIT CARD AUTHORIZATION FORM

It is a policy of this practice to keep a credit card on file in case of a "no show" visit (late or no cancellation). Your credit card information will be protected along with the rest of your information. You may also choose to have this credit card charged with your regular session fees.

Patient's Name ______________________________

Cardholder's Name ______________________________

Billing Address ______________________________

____

Credit Card Type Visa Mastercard American Express Discover

Credit Card Number ______________________________

Expiration Date ____________________ CCVS/CVC2/CID ________

I have read and agree with the office's policy of keeping my credit card information on file. This information may be used for payments of past due balances and/or no show visits. Regular fees will be charged with my verbal permission. I understand that this authorization will remain in force until Dr. Juneja has received written notification from me of its termination in such time and in such manner as to afford Dr. Juneja a reasonable opportunity to act on it.

Authorized Signature ______________________________ Date ________________

Sonia Juneja, M. D.
Patient Medical History Form

Today's Date ___/___/___

Name ____

Date of Birth ___/___/___ Age: ____ Sex: ___Female ___Male

Describe briefly your present symptoms/problems: ______________________________________

____

____

Please list other practitioners you have seen for this problem: ____________________________

____

Please provide details regarding any outpatient psychiatric treatment/psychotherapy you may have had in the past: ____

____

____

____

____

Are you currently in treatment with a mental health professional? _________________________

Psychiatric Hospitalizations (include where, when, for what reason and psychiatric diagnosis)____

____

____

Drug Allergies: ___ Yes ___ No To What?____

CURRENT MEDICATIONS

Please list any medications that you are taking now. Include non-prescription medications and vitamins or supplements.

Name of Medication	Dose (strength & number of pills/day)	How long have you been taking?

PAST MEDICAL HISTORY

Do you now or have you ever had:

___ Diabetes
___ High Blood Pressure
___ High Cholesterol
___ Hypothyroidism
___ Goiter
___ Cancer (type)_________
___ Leukemia
___ Psoriasis
___ Angina
___ Heart problems
___ Heart Murmur
___ Pneumonia
___ Pulmonary Embolism
___ Asthma
___ Emphysema
___ Stroke
___ Epilepsy (Seizures)
___ Cataracts
___ Kidney disease
___ HIV/AIDS
___ Crohn's Disease
___ Colitis
___ Anemia
___ Jaundice
___ Hepatitis
___ Peptic ulcer
___ Rheumatic Fever
___ Tuberculosis
___ Liver disease

Other medical Condition (please list) ____

PERSONAL HISTORY

Were there any problems with your birth ____

Where were you born and raised ____

What is your highest education?

____ High School ___ Some College ___ Graduate ___ Advanced Degree

Marital Status: ___ Never Married ___ Married ___ Separated ___Divorced ___ Widowed
___ Partner/Significant other

What is your current or past occupation ____

Are you currently working ___ Yes ___ No Hours/wk. _________

If not, are you: ___ Retired ___ Disabled ____Sick Leave

Do you receive disability or SSI? ___ Yes ___ No

If yes, for what and how long ____

Have you ever had legal problems (specify) _____________________________________

____

FAMILY HISTORY

	If Living		If deceased	
	Age	Psychiatric Condition	Age at death	Cause of Death
Father				
Mother				
Siblings				
Children				

Extended Family Psychiatric Problems – Past or Present:

Maternal Relatives ____
Paternal Relatives ____

SUBSTANCE USE HISTORY

Drug Category	**Age when you first used this**	**How much and how often did u use?**	**How many years did you use?**	**When did you last use this?**	**Do you currently use this?**
ALCOHOL					YES NO
CANNABIS *Marijuana, Hashish, Hash Oil*					YES NO
STIMULANTS *Cocaine, Crack*					YES NO
AMPHETAMINS/STIMULANTS *Ritalin, Dexedrine, Adderall*					YES NO
BENZODIAZEPINES/TRANQUILIZERS *Valium, Librium, Xanax, "Roofies"*					YES NO
SEDATIVES/ HYPNOTICS *Amytal, Seconal, Phenobarbital, Dalmane*					YES NO
HEROIN					YES NO
STREET OR ILLICIT METHADONE					YES NO
OTHER OPIOIDS *Tylenol 2, #3, percodon, Percocet, opium, Demerol, dilaudid,*					YES NO
HALLUCINOGENS *LSD, PCP, STP, MDA, DAT, mushrooms, ecstasy, mescaline*					YES NO
INHALANTS *Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room*					YES NO
OTHER *Specify;*					YES NO

Sonia Juneja, M.D.
Washington Family Psychiatry LLC
Use and Disclosure of Protected Health Information

SECTION I: Patient Acknowledgement and Consent Form

The educational pamphlet entitled “Notice of Privacy Practices” provides information about how Sonia Juneja, M.D., may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). My Notice of Private Practices states that I reserve the right to change terms described. Should this happen, I will display the new policy and effective date at my office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. I am not required to agree with your restrictions; but if I do, I am bound by our agreement with you.

By signing below, you acknowledge receipt of my Notice of Privacy Practices.

____ ____________________________

Patient’s Signature Date

____

Print Full Name

SECTION II: Personal Representative, Family or other entities authorized access to Protected Health Information

Name or specifically identify the person and /or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

________________________________ ______________________ ______________

Name of Authorized Person or Entity Relationship Phone

________________________________ ______________________ ______________

Name of Authorized Person or Entity Relationship Phone

SECTION III: Authorization for us of Answering Machine and/or Voice Mail

This practice is routinely unable to contact patients directly during normal business hours. On these occasions, my office leaves messages on communication devices provided by my patients. Due to federally mandated HIPAA Privacy Rule, I must obtain your authorization to continue this mode of communication. Protected Health Information that I may possibly disclose on your home, work or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, and appointment instructions.

_____ (Initial) Yes, I agree to allow Sonia Juneja, M.D., and staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work, cell.

_____ (Initial) I agree to allow Sonia Juneja, M.D., and staff to leave message that include Protected Healthcare Information on the following:

Please initial next to the applicable communication devices:

_____ home number _____ work number OR _____ cell number

_____ (Initial) No, I do NOT agree to allow Sonia Juneja, M.D., and staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

____ ______________________________

Patient’s Signature Date